IDENTIFICATION NUMBER: 158654  NAME OF PROVIDER OR SUPPLIES  ENGLEWOOD HEALTH & REHABILITATION CENTER  ENGLEWOOD HEALTH & REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFER GRAD DEFICIENCY MIST BE PERCEIDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION)  A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 12/01/11  Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110  Surveyor: Amy Kelley, Life Safety Code Specialist  At this Life Safety Code survey, Englewood Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to be of Type V (111)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
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NAME   DESCRIPTION   SUMMARY STATEMENT OF DEFICIENCIES   TAG   PREFEX   (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG   PREFEX   (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG   PREFEX   TAG   DEFICIENCY MIST BE PERCEDED BY FULL TAG   DEFI								
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determined to be of Type V (111)		IAC 16.2.						
determined to be of Type V (111)								
		This one story	facility was					
LADODATORY DIDECTORS OF REQUIREMENT REPRESENTATIVES SIGNATURE.		determined to	be of Type V (111)					
	LABORATOR	V DIBECTORIS OF PRO	AUDED (CLIDDLIED DEDDECENTA TRACE CA	CNIATUR	P	TITLE		(VC) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M4F121

Facility ID:

000498

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155654		A. BUILDING	E CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 12/01/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	223	EET ADDRESS, CITY, STATE, ZIP CODE 7 ENGLE RD RT WAYNE, IN46809	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
	alarm system we detection in the open to the corbas a capacity of census of 59 at survey.  Quality Review by I Code Specialist-Med  The facility was compliance with aforementioned.	ne facility has a fire vith smoke e corridor and areas ridor. The facility of 67 and had a the time of this  Robert Booher, Life Safety dical Surveyor on 12/02/11.			
K0029 SS=E	fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the	em option is used, the areas on other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches the door are permitted.	K0029	The following Plan of Correct constitutes our written allega	tion
	ensure the corr resident record	acility failed to doors to 1 of 2 s storage rooms les, measuring over		of compliance for the deficient cited. Submission of the Plar Correction is not an admission that a deficiency exists or the one was cited correctly. This	ncies n of on at

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155654	B. WIN	G		12/01/2	011
NAME OF I	PROVIDER OR SUPPLIEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NO VIDER OR SOLITEIE				NGLE RD		
ENGLEV		REHABILITATION CENTER		FORT V	VAYNE, IN46809		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG			+	TAG	of Correction is submitted to	meet	DATE
	50 square feet				requirements established by		
	provided with				and federal law.		
		eficient practice			1. The facility has removed a		
		y resident near the			alleged boxes that are not st from the business office. The		
	Business office	2.			facility added a self closing d		
	e	1			to all three alleged shower ro		
	Findings includ	de:			doors.  2. The alleged deficiency had	d the	
	Pacad an aba-	nuntion with the			potential to affect all resident		
		rvation with the			3. Maintenance Supervisor w	/ill	
	Maintenance D				audit to ensure that the show	er/	
		2:00 p.m., both			room doors are self closing	fico	
		to the Business			properly and the business of is free from unstored boxes.	iice	
		nbustible storage,			Maintenace Supervisor wi	II	
	_	r 50 square feet in			check the business office an		
	size, lacked a s	self closing device.			shower rooms weekly x4 the	n	
	The Business o	office contained six			monthly thereafter until compliance is achieved. Res	ulte	
	cardboard box	es of resident			will be forwarded monthly to		
	records and ot	her documentation.			QA Committee Meeting.		
	This was ackno	owledged by the			5. To be completed by 12/30	/11.	
	Maintenance D	irector at the time					
	of observation						
	2.1.10(b)						
	3.1-19(b)						
	2. Based on ol	bservation and					
		facility failed to					
		ridor door to 3 of 3					
		used for storage of					
		erefore creating a					
	•	a, were provided					
		at would self close					
	and latch into the frame. This						
	deficient practice could affect all						
	dencient pract	ice could affect all					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/01/2011	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STF 22	REET ADDRESS, CITY, STATE, ZIP 37 ENGLE RD DRT WAYNE, IN46809	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
	residents.					
	Findings includ	e:				
	were stored in on the 100, 200. These shower redoors lacked la and did not late frame. Based of the Maintenance time of observations are stored in the	irector on 12:14 p.m. to led linen barrels the shower rooms 0 and 300 halls. coms' corridor tching hardware ch into the door on an interview with te Director at the ation, soiled linens tese barrels until by the laundry staff				
K0046 SS=C	duration is provided 19.2.9.1.  Based on record interview, the frequency 1 of 8 effixtures of at least	acility failed to mergency light east 1½ hour ested annually in h LSC 7.9. LSC	K0046	The following Plan of constitutes our written of compliance for the cited. Submission of Correction is not an that a deficiency existence of Correction is submission.	en allegation e deficiencies f the Plan of admission sts or that ctly. This Plan	12/30/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M4F121 Facility ID:

000498

If continuation sheet Page 4 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155654	B. WIN			12/01/20	011
ENGLEV		REHABILITATION CENTER	•	2237 EN FORT V	DDRESS, CITY, STATE, ZIP CODE NGLE RD VAYNE, IN46809		avo.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	`				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	
TAG	Emergency Lig requires an and conducted on a battery powered lighting system 1½ hour duration of the records of visus tests shall be keepergeneration of the for inspection having jurisdict practice could based on review "Battery-Operation of the "Battery-Operation of the "Battery-Operation of the "Battery-Operation of the "Battery-Operation" in the generator.	hting Equipment nual test shall be every required ed emergency n for not less than a tion. Equipment perational for the el test. Written al inspections and kept by the owner by the authority tion. This deficient affect all occupants.  de:  w of the kted Emergency n the Maintenance /01/11 at 11:08 s no documentation est on the battery gency task light at This was by the Maintenance		TAG		state  vill he de d the s. ery c. test or 90 n the hic e	DATE

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654		LDING	onstruction 01	(X3) DATE COMPL 12/01/2	ETED
ENGLEW		EHABILITATION CENTER		STREET A 2237 EN FORT V	ADDRESS, CITY, STATE, ZIP CODE NGLE RD VAYNE, IN46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0048 SS=C	patients and for the of an emergency. Based on record interview, the faprovide a writter included the usex extinguishers in kitchen fire extroprotection of 5the event of an 19.7.2.2 requirecare occupancy that shall provifollowing:  (1) Use of alarm (2) Transmission fire department (3) Response to (4) Isolation of (5) Evacuation of (6) Evacuation of (7) Preparation building for evaluation of (8) Extinguishm This deficient pany number of event of an emergency in the standard compartment (7) Preparation building for evaluation of (8) Extinguishm This deficient pany number of event of an emergency included the standard compartment (8) Extinguishm This deficient pany number of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event of an emergency in the standard comparation of event	acility failed to en fire plan that se of all fire including the inguishers for the 9 of 59 residents in emergency. LSC es a written health of fire safety plan de for the is in of alarm to the t o alarms fire of immediate area of smoke  of floors and acuation nent of fire oractice could affect occupants in the ergency.	K	0048	The following Plan of Correct constitutes our written allegated of compliance for the deficiencited. Submission of the Plan Correction is not an admission that a deficiency exists or the one was cited correctly. This of Correction is submitted to requirements established by and federal law.  1. The facility will update the alleged current fire plan to in all necessary information.  2. The alleged deficiency has potential to affect all residents.  3. Maintenance Supervisor winservice all staff on the updated fire plan located at enurses station.  4. The updated fire plan will reviewed, updated and inser annually.  5. To be completed by 12/30	tition ncies n of on at Plan meet state  clude d the is. vill ated an each be viced	12/30/2011

AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155654			LDING	01	(X3) DATE COMPL 12/01/2	ETED	
	PROVIDER OR SUPPLIER	EEHABILITATION CENTER		2237 EI	ADDRESS, CITY, STATE, ZIP CODE NGLE RD NAYNE, IN46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0069 SS=E	Policy and Proc documentation the use of the fincluding the K extinguisher loin relationship kitchen hood e system. Based with the Mainte the time of rec documentation review.  3.1–19(b)  Cooking facilities with 9.2.3. 19.3  Based on obserview, the finaintain 1 of 1 fire extinguisher cooking area in the requirement Standard for Policy Extinguishers, 10, 2–3.2 requirement extinguishers, 10, 2–3.2 requirement combustib	did not address fire extinguishers class fire extinguishers cated in the kitchen with the use of the xtinguishing on an interview enance Director at ord review, no other was available for extinguishing facility failed to K Class portable ers in the kitchen accordance with the story of NFPA 10, ortable Fire 1998 Edition. NFPA ires fire provided for the pooking appliances le cooking media nimal oils and fats) and labeled for	K(	0069	The following Plan of Correct constitutes our written allegt of compliance for the deficiencited. Submission of the Plate Correction is not an admission that a deficiency exists or the one was cited correctly. This of Correction is submitted to requirements established by and federal law.  1. The facility placed a place conspicuously near the class extinguisher in the kitchen at 2. The alleged deficiency has potential to affect the 32 reson 100 & 200 Hall.  3. Maintenance Supervisor inservice Dietary Staff on the supervisor in the supervisor in the supervisor inservice Dietary Staff on the supervisor in the superviso	ation encies in of ion at s Plan meet r state ard s K irea. ad the idents will e fire	12/30/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155654	B. WIN	G		12/01/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
ENOLE/A	VOOD LIEALTIL 8 E	DELIADII ITATION CENTED			NGLE RD		
		REHABILITATION CENTER	ı		VAYNE, IN46809		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	1	NFPA 10, 2-3.2.1			protection system, including	the	
	requires a plac				class K extinguisher.		
	1 .	placed near the			Maintenance Supervisor will review monthly to ensure the		
	1	hich states the fire			placard is still in place. All re		
	protection syst				will be recorded on the TELS		
	1 -	to using the fire			electronic record.	oio	
	Ī	Since the fixed fire			The facility has an electron     audit tool for the Maintenance		
	extinguishing				Supervisor to do the monthly	,	
		shut off the fuel			checks. Results will be forward	ırded	
	source to the o	cooking appliance,			monthly to QA Committee Meeting.		
	the fixed syste	m should be			5. To be completed by 12/30	/11.	
	activated befor	re using a portable					
	fire extinguish	er. In this instance,					
	the portable fi	re extinguisher is					
	supplemental ¡	protection. This					
	deficient pract	ice could affect any					
	residents using	g the main dining					
	room, located	adjacent to the					
	kitchen.						
	Findings includ	de:					
		rvation with the					
	Maintenance D						
	12/01/11 at 1	•					
		s fire extinguisher					
	· ·	rd. Based on an					
	interview with the Maintenance						
	Director at the						
	1	ne kitchen K Class					
	fire extinguisher lacked a placard						
	identifying its use as secondary						
	backup to the	kitchen automatic					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MULTIPLE C	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  12/01/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2237 E	ADDRESS, CITY, STATE, ZIP CODE ENGLE RD WAYNE, IN46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	fire suppressio	n system.				
	3.1-19(b)					
K0018 SS=E	than required enclexits, or hazardou doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with keeping the door meeting 19.3.6.3.6.  Roller latches are regulations in all h Based on obserinterview, the fensure 1 of 15 corridor doors closed and latc frame. This decould affect an residents on the Findings include Based on obserintenance Di 12/01/11 at 12 corridor doors to corridor door door door door door door do	prohibited by CMS ealth care facilities. vation and acility failed to resident room on the 300 hall hed into the door ficient practice y of the 27 e 300 hall.  e: vation with the irector on	K0018	The following Plan of Correct constitutes our written allegated of compliance for the deficient cited. Submission of the Plan Correction is not an admission that a deficiency exists or the one was cited correctly. This of Correction is submitted to requirements established by and federal law.  1. The alleged deficient door room 315 has been realigned fixed to latch properly.  2. The alleged deficiency has potential to affect the 27 resion the 300 Hall.  3. Maintenance Supervisor with the submission of the submi	ation ncies n of on at Plan meet state to d and d the dents will dor oe	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M4F121 Facility ID:

000498

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CON	ISTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	02	COMPL	
		155654	B. WING			12/01/2	011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2	2237 EN	DDRESS, CITY, STATE, ZIP CODE GLE RD AYNE, IN46809		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	CAG	DEFICIENCY)		DATE
		as acknowledged by te Director at the ation.			tool. 4. The facility will create an electronic audit tool to check monitor for compliance mont Results will be forwarded mot to the QA Committee Meetin 5. To be completed by 12/30	hly. onthly g.	
K0144 SS=F	exercised under lomonth in accordar 3.4.4.1. Based on interview, the facithe off site fue emergency gerreliable source Edition, Standa and Standby Pochapter 3, Emesupply (EPS), 3 states the follo sources shall be for the emerge (EPS): a) Liquid petrol atmospheric problem Liquefied peror vapor withdred in Natural or sy exception: For	ergency Power -1.1 Energy Sources wing energy e permitted for use ncy power supply leum products at ressure troleum gas (liquid rawal) onthetic gas Level 1 locations where the	K014	14	The following Plan of Correct constitutes our written allegated of compliance for the deficiencited. Submission of the Plan Correction is not an admission that a deficiency exists or the one was cited correctly. This of Correction is submitted to requirements established by and federal law.  1. The facility will obtain an occumpany letter from an off sifuel source.  2. The alleged deficiency has potential to affect all resident 3. Maintenance Supervisor to inserviced on the importance need to have an emergency site fuel source in place and review annually.  4. Maintenance Supervisor wreview and update an off site emergency fuel source annuals.  5. To be completed by 12/30	ation ncies n of on at Plan meet state official te d the ts. o be and off	12/30/2011

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	02	l ´	E SURVEY PLETED	
THIS TEAM	or condition	155654	1	LDING			/2011
		1888	B. WIN		DDDEGG CITY GTATE 711	_	,2011
NAME OF P	PROVIDER OR SUPPLIEF				ddress, city, state, zii NGLE RD	r CODE	
ENGLEW	OOD HEALTH & R	EHABILITATION CENTER			VAYNE, IN46809		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETION DATE
TAG				TAG		<u> </u>	DATE
		pplies is high (e.g., ake, flood damage					
	or demonstrate						
		n-site storage of an					
		y source sufficient					
	to allow full ou						
		ver supply system					
		livered for the class					
		be required, with					
	the provision for						
	· ·	he primary energy					
		Iternate energy					
	source.	iternate energy					
	CMS (Centers f	or					
	Medicare/Medi						
	· ·	r of reliability from					
	-	vendor regarding					
	_	that must contain					
	the following:						
	_	t of reasonable					
	reliability of th	e natural gas					
	delivery.	-					
	2. A brief desc	ription that					
	supports the st	atement regarding					
	the reliability.						
	3. A statemen	t that there is a low					
	probability of i	nterruption of the					
	natural gas.						
	4. A brief desc	ription that					
	supports the st	atement regarding					
	the low probability of interruption,						
	5. The signature of a technical						
	person from th	e natural gas					
	5. The signatu	re of a technical					

000498

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155654		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 02	(X3) DATE ( COMPL 12/01/20	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET A	DDRESS, CITY, STATE, ZIP CODE NGLE RD VAYNE, IN46809		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	all residents, st	oractice could affect caff and visitors.					
	Maintenance D 12/01/11 at 1 letter regarding fuel source for generator was Management a gas provider. I interview with	d review with the irector on 1:00 a.m., the only g the natural gas the emergency from TLC and not the natural Based on an the Maintenance time of record					
K0147 SS=E	Electrical wiring an accordance with N Code. 9.1.2	nd equipment is in IFPA 70, National Electrical					
	Based on obse	vation and	KO	)147	The following Plan of Correct	tion	12/30/2011

AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	A. BUI	LDING	NSTRUCTION  02	(X3) DATE SURVEY COMPLETED 12/01/2011			
NAME OF PROVIDER OR SUPPLIER  ENGLEWOOD HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  2237 ENGLE RD  FORT WAYNE, IN46809					
	SUMMARY S (EACH DEFICIENT REGULATORY OR Interview, the fensure 6 of 11 resident rest rollocation, were ground fault cit (GFCI) protections as arronditions. The standing fluids drenching of the of which conditions are conditions. The standing fluids drenching of the patient or so 517–20 Wet Loreceptacles and within the area to have GFCI per can reduce the of the body, are insulation is medialure. This decould affect 17 300 hall in the electrical short	EHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Tacility failed to of the 300 hall rooms, a wet provided with reuit interrupter on against electric o, Article 517, cilities, defines wet eas subjected to wet ese include on the floor or ne work area, either tion is intimate to staff. NFPA 70, cations, requires all d fixed equipment of the wet location rotection. Moisture contact resistance d electrical ore subject to efficient practice residents on the event of an	B. WIN	STREET A	NGLE RD	ation ncies n of on at s Plan with d the idents will ets to test and thly. I test nthly until sults QA	(X5) COMPLETION DATE		
	Maintenance D 12/01/11 from 12:59 p.m., the	oservations with the irector on 12:48 p.m. to							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	M4F121	Facility I	D: 000498 If continuation :	sheet Pa	ge 13 of 14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	A. BUILDING 02 COI		COMPL	DATE SURVEY COMPLETED /01/2011				
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE					
ENGLEWOOD HEALTH & REHABILITATION CENTER					2237 ENGLE RD FORT WAYNE, IN46809					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
	resident room 308/310 and 3 electrical recep located twenty hand sink. Wh were tested wit device provided the button was Maintenance D not interrupted interview with the Supervisor at the supe	the Maintenance ne time of ese receptacles								